Report on Medicaid Reform Activities
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Health and Human Services Committee
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Introduction

This report is a summary of Medicaid reform activities to date, and offers preliminary thoughts and preliminary conclusions about the Nebraska Medicaid program generally and Nebraska Medicaid reform in particular. It does not necessarily reflect the views of both Medicaid reform designees, and is offered in addition to Preliminary Findings and Recommendations of both designees also contained in this monthly report.

As the last monthly report before Medicaid reform public input meetings are conducted during the weeks of October 24 through November 4, 2005, it is intended to provide a necessary background and format for obtaining input from the public at those meetings.[1]

Medicaid Reform Activities

To date, the Medicaid reform designees have received significant feedback regarding Medicaid reform in the form of (1) written reports, recommendations and other feedback,[2] (2) meetings with various individuals and groups,[3] and (3) HHSS internal work groups.[4]

The Medicaid reform designees have also reviewed Nebraska Medicaid and related statutes[5] and Medicaid reform proposals from other states,[6] and conducted other research on the topic of Medicaid reform.

The Nebraska Legislature has defined four purposes for Medicaid reform[7] and seven areas that must be considered and addressed in the Medicaid reform plan.[8]

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[1] See Attachment 1.
[2] See Attachment 2.
[3] See Attachment 3.
[4] See Attachment 4.
[5] Neb. Rev. Stat. §§68-1001 to 68-1086.
[6] See attached report by Director Nelson.
[7] "The purpose of the Medicaid Reform Act is to provide for reform of the medical assistance program established in section 68-1018, also known as medicaid, and a substantive recodification of statutes relating to such program, including, but not limited to, the enactment of policies to (1) moderate the growth of medicaid spending, (2) ensure future sustainability of the medical assistance program for Nebraska residents, (3) establish priorities and ensure flexibility in the allocation of medical assistance benefits, and (4) provide alternatives to medicaid eligibility for Nebraska residents." Neb. Rev. Stat. § 68-1090, LB 709 (2005).
[8] "(2) It is the intent of the Legislature that such plan consider and address: (a) The needs of low-income, disabled, and aged persons currently receiving medicaid services; (b) avoiding the shifting of the primary costs of health care services to providers of care; (c) the appropriate role of county government in providing health care services; (d) the availability and affordability of private health care insurance and long-term care insurance; (e) the personal responsibility of persons, who are able, to select and provide for all or a portion of the payment for their health care services; (f) the fiscal sustainability of such plan; and (g) alternatives to increase federal funding for services in order to reduce dependence on General Funds. . . ." Neb. Rev. Stat. § 68-1091(2), LB 709 (2005).

Medicaid Generally

Medicaid is a state-federal partnership administered as a welfare entitlement program within broadly established federal guidelines under Title XIX of the federal Social Security Act. The cost of the program is shared by the state and federal government (approximately 60% federal, and 40% state). Nebraska has also established a Children's Health Insurance Program as a Medicaid expansion under Title XXI of the federal Social Security Act. The combined Medicaid program for children is called "Kid's Connection."

The state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets payment rates for services; and administers the program on a day-to-day basis. Core federal requirements applicable to all state Medicaid programs include (1) statewideness, (2) comparability, (3) freedom of choice, and (4) sufficiency in amount, duration, and scope of Medicaid services. Portions of federal Medicaid authorizing legislation may be "waived" to provide states with greater Medicaid flexibility.

Elements of a state Medicaid program must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid "state plan" is a comprehensive written document, developed and amended collaboratively with CMS, that describes the nature and scope of the state's Medicaid program, and gives assurances that the state will administer the program in compliance with federal requirements.

Medicaid is (1) a chronic and long-term care program for low income seniors and persons with disabilities; (2) a supplement to Medicare for this same population; (3) an insurance-like program for low income pregnant women, children and some parents; and (4) a funding source for safety net hospitals and community health centers that serve a disproportionately high share of uninsured persons. Medicaid coverage includes both federally mandated and state optional services and eligible persons.

Medicaid in Nebraska is shaped by public policy established by the United States Congress and the Nebraska Legislature and the complex interaction of four interrelated elements: (1) eligibility, (2) services, (3) reimbursement, and (4) administration. Medicaid program costs are affected by (1) caseload (determined by eligibility criteria), (2) utilization (determined by services covered and service limits), and (3) unit price (determined by provider reimbursement rates).

Total Medicaid appropriations grew from $201 million in FY 86-87 to $1.4 billion in FY 06-07, from 8.6% of state General Fund appropriations to 17.8%, from a monthly average of 88,000 eligible persons to 200,000. The average annual growth in Medicaid appropriations during the period was 10.8%. Average annual growth in General Fund revenues during the period was 6.9%;[9]

The majority of Medicaid beneficiaries in FY 04-05 were children and pregnant women (64.5%), but the majority of Medicaid expenditures (66.7%) were made on behalf of the elderly and disabled. The highest Medicaid expenditures in FY 04-05 were for nursing home care, inpatient hospital services, and prescription drugs. Total Medicaid long-term care expenditures were approximately 36.3% of the Medicaid budget in FY 04-05.

Since their original adoption in 1965, Nebraska Medicaid statutes have been amended approximately 46 different times in 26 different legislative sessions.

[9] Nebraska Department of Administrative Services, Budget Division; Nebraska Health and Human Services System; Nebraska Legislative Fiscal Office.

Medicaid reform

Medicaid reform is motivated by the fact that (1) many Nebraskans have health care, long-term care, and related needs, and are unable, without assistance, to meet those needs; (2) more people will be requiring more health care, long-term care, and related services in the future as the population of Nebraska grows and the number of elderly Nebraskans increases; (3) as more people require more services, total Medicaid General Fund appropriations will continue to grow at a rate faster than the growth in state General Fund revenues; and (4) the Medicaid program as currently structured and operated will not effectively moderate the growth of Medicaid spending and cannot be fiscally sustained.

Medicaid reform is difficult, because (1) it is deeply personal; (2) it is extremely complex; (3) it is highly political; and (4) it is tenuously dependent on administrative and legislative actions by federal and state government.

Medicaid reform was mandated by the Nebraska Legislature in LB 709 (2005) and the Nebraska Medicaid Reform Act.[10] The act requires development of a Medicaid reform plan by two persons, one appointed by Governor Dave Heineman and one appointed by Senator Jim Jensen as chair of the Legislature's Health and Human Services Committee. The designees are Richard Nelson, Director of HHS Finance and Support, and Jeff Santema, legal counsel to the Health and Human Services Committee of the Nebraska Legislature.

The designees must: (1) consult with the Governor, the Health and Human Services Committee, the HHSS Policy Cabinet, and the federal Centers for Medicare and Medicaid Services (CMS); (2) solicit public input; (3) conduct at least one public meeting in each congressional district; (4) provide monthly reports to the Governor and the committee; (5) meet monthly with the Medicaid Reform Advisory Council; and (6) develop and submit a Medicaid reform plan to the Governor and the Legislature by December 1, 2005.

The Health and Human Services Committee of the Legislature must conduct a public hearing on the plan by December 15, 2005. Senator Jensen as chair of the Health and Human Services Committee, in consultation with the committee, may introduce legislation in 2006 to implement the plan.

LB 709 establishes a Medicaid Reform Advisory Council consisting of ten persons, five appointed by the Governor and five appointed by Senator Jensen as chair of the Legislature's Health and Human Services Committee, and representing health care providers, health care consumers/advocates, business, insurers, and elected officials. Members of the council are Senator Don Pederson (chair), Kathy Campbell (vice chair), Gayle-ann Douglas, Mary Lee Fitzsimmons, Steve Martin, Ron Ross, Wayne Sensor, Cory Shaw, Pat Snyder, and Tony Sorrentino.

The Medicaid Reform Advisory Council must (1) meet monthly with the Medicaid reform designees; (2) review monthly reports submitted to the Governor and committee by the designees; and (3) review the Medicaid reform plan and provide recommendations relating to the plan to the Governor and the committee by December 14, 2005. The council is <u>not</u> required to develop the plan, and is only one source of input to the designees during development of the plan.

[10] Neb. Rev. Stat. §68-1087 to 68-1094.

Medicaid Reform Discussion and Preliminary Conclusions

Role of Government

Medicaid was established forty years ago to provide publicly (i.e. taxpayer) funded medical assistance for needy individuals. Much has changed since 1965, but Medicaid continues to be a welfare entitlement program that consumes an ever-increasing portion of state and federal budgets. The program has become increasingly bureaucratic and complex, increasingly difficult to administer, and has arguably been unable to solve the problem it was originally created to solve.

The fundamental question still remains: What is the role and responsibility of government in helping to meet the health care and long-term care needs of its citizens? In an environment of unlimited needs and limited resources, government can only do so much, and others will be left to do the rest. It is not only a question of how much assistance, but of what kind of assistance should government provide, and to whom.

Medicaid is a program of inherently unrealistic expectations and unrealistic demands. Unless realistic and appropriate limits can be placed on government's role in the provision of medical assistance, Medicaid will never be truly reformed.

Medicaid cannot be the vehicle to achieve a utopian ideal of meeting all Nebraskans' health care and long-term care needs, just as state welfare assistance programs, by themselves, cannot be the vehicle to eliminate poverty. Medicaid reform should not seek to expand the role of government to meet a goal that is ultimately unattainable.

Placing limits on the role of government is fundamentally a question of setting priorities. How can government best spend the resources entrusted to it by Nebraska taxpayers to achieve the greatest good for the greatest number of people, with maximum flexibility and controlled expenditure growth? Medicaid must become more of a public-private partnership, in which government is not seen as the dominant partner. Government cannot do it all, and should not be expected to. Compassion is not government's responsibility alone, and government, or bureaucratic, "compassion" is inherently inferior to personal compassion.

If government is seen as the ultimately responsible "provider" or "caretaker" for those in need, Medicaid will never be reformed. Government should be seen rather as a strong but limited partner in helping to facilitate the creation of an environment in which the health and welfare of its citizens is most effectively and efficiently promoted.

That is not to say, however, that Medicaid is unimportant. Medicaid plays a vitally important role, and therefore cannot be abandoned. The goal of fiscal sustainability is important so that Medicaid will be a strong and stable resource for future generations of Nebraskans.

Welfare Entitlement

Medicaid is fundamentally a welfare entitlement, or "defined benefit," program, in which eligibility and benefits are essentially fixed, but costs are variable. In a "defined contribution" model, eligibility and costs are fixed, but benefits are variable, and targeted to meet individual needs.

In discussing the difference between a defined benefit and a defined contribution approach, one writer has noted that, in a defined benefit environment, cost containment becomes

a priority rather than quality and access to care. In a defined contribution model, more attention can be given to quality assurance and patient satisfaction.[11]

Some states are beginning to explore ways of shifting their Medicaid programs from a defined benefit to a defined contribution model, in an effort to provide greater quality and access to care, within reasonable expenditure limits. In the long term, Medicaid reform in Nebraska must explore ways to make a similar paradigm shift. True reform cannot be achieved unless the underlying premise of Medicaid is reformed. The defined benefit nature of Medicaid is arguably the single greatest contributor to uncontrolled expenditure growth in the program. Changing to a defined contribution approach, however, is very complicated and requires a great deal of intensive planning and extended negotiation with the federal Centers for Medicare and Medicaid Services, and should only be done with great care.

Short-Term Reform

In the short term, several things can be done to achieve necessary expenditure controls, without drastically cutting eligibility or provider reimbursements.

1. Focus on high-cost areas and populations.

The greatest Medicaid expenditures are for long-term care, inpatient hospital services, and prescription drugs. The highest percentage of Medicaid expenditures are made on behalf of the elderly and disabled. As Director Nelson has noted, appropriate changes should be made to encourage the further development of lesser intensive home and community-based services, and greater attention should be given to managing the care and expenditures on behalf of the program's most costly recipients.

2. Focus on administration.

Short-term reforms should focus on strengthening and making administrative improvements to the program. Without adequate technology and other supports, program administration will be inadequately equipped to do its work most effectively. Enhanced oversight and more effective management will require additional resources in the short term, but will result in greater short-term and long-term savings to the program overall. Reform should also strive to achieve administrative simplification and the removal of any unnecessary and burdensome complexity and rigidity from the program.

3. Focus on access and the private sector.

Medicaid reform should explore and encourage the development of more federally qualified community health centers to meet the primary health care needs of indigent Nebraskans. In addition, immediate reforms should focus on enhancing private sector participation in providing access to needed health care services for Nebraskans. This could take the form of encouraging the provision of more employer-sponsored health insurance, encouraging the purchase of long-term care insurance and the utilization of other personal long-term care financing strategies, and encouraging the passage of state mental health parity legislation.

[11] Richard Teske, "Abolishing the Medicaid Ghetto: Putting 'Patients First'", American Legislative Exchange Council, 2002, http://www.alec.org/meSWFiles/pdf/0206.pdf

4. No program expansions in eligibility, benefits, or provider reimbursements.

Great anxiety and concern has been expressed over the possibility of making drastic cuts in Medicaid eligibility, benefits, or provider reimbursements as part of Medicaid "reform." These concerns arise from the assumption that Medicaid reform is only about cutting the Medicaid budget. While it is true that the budget is important and must be considered, the effect of any proposed fiscal constraints on current Medicaid eligibles must also be a top priority. Medicaid reform, therefore, should identify and implement appropriate expenditure controls, without imposing any contractions in current eligibility, benefits, or provider reimbursements, or expansions that would result in increased costs to the Medicaid program. Medicaid reform must consider necessary and appropriate improvements, however, that can, and should, be made to methodologies and processes used in determining eligibility and provider reimbursements.

5. Explore alternative funding mechanisms to offset increases in General Fund expenditures.

Alternative financing strategies should be explored to offset the growth in Medicaid General Fund expenditures. Director Nelson has highlighted some of these strategies in his October monthly report, but has also expressed some caution about their implementation.

Statutory Recodification

Medicaid statutes in Nebraska were first adopted in 1965, and became effective on July 1, 1966. Nebraska state law now contains several desperate provisions, in Chapter 68, and article 10, that have been added since the program's inception.[12]

Medicaid reform legislation in 2006 should focus on both technical and substantive goals. Technical goals should include repealing obsolete and unnecessary provisions, reformatting existing provisions, and making clarifying changes to existing statutory language.

Substantive goals should include (1) an explicit statement of public policy for the Medicaid program, (2) changes to provide more flexibility and permit the implementation of administrative and other reforms to the program, (3) explicit directives for the exploration and implementation of long-term reforms, and (4) necessary and appropriate changes in Medicaid-related statutes to accomplish other reform objectives.

Medicaid reform legislation in 2006 must be clearly substantive in order to comply with legislative intent expressed in LB 709 (2005).

[12] See Attachment 5.

Attachment 1
Schedule and Proposed Format for Medicaid Public Input Meetings

Medicaid Public Input Meetings:
(All meetings at 7:00 p.m. local time)

October 25, 2005 (Tuesday)
Omaha
TAC Building
Board Room
3215 Cumming Street

October 26, 2005 (Wednesday)
Lincoln
State Capitol, Room 1510
1445 K Street

October 27, 2005 (Thursday)
Grand Island
City Hall
Community Meeting Room (CMR)
100 East 1st Street

November 1, 2005 (Tuesday)
Scottsbluff
Western Nebraska Community College
WNC Harms Advanced Technology Center
2620 College Park

November 2, 2005 (Wednesday)
North Platte
Mid-Plains Community College
601 West State Farm Road

Proposed Format for Medicaid Reform Public Input Meetings
(7:00 – 9:00 p.m. local time)

1. Presentation a. Overview of Medicaid b. Overview of Medicaid reform (LB 709) c. Overview outline of Medicaid reform preliminary recommendations and questions for feedback and discussion	20-30 minutes
2. Introduce Discussion/Feedback	10 minutes
3. Public Discussion/Feedback	80-90 minutes

Attachment 2
Written Recommendations Received from External Organizations as of October 7, 2005

Source	Subject	Recommendation
Nebraska Medical Association (NMA)	Long Term Care	1) Nursing Facilities/HCBS Waiver Services – support for community services, which allow the elderly to remain at home or in assisted living arrangements should help keep these costs down. Monitoring these programs for cost effectiveness will be important.
		2) Support for a long-term care insurance program which is simple and affordable could make a significant impact in these costs in the future. Coverage for even two years of care would have a significant impact if a large percentage of people were covered.
	Pharmacy	3) A restricted formulary with generic drugs should be evaluated. Most of the time generic drugs are as effective and safe as branded products.
		4) A low-hassle way to obtain a branded drug when clearly needed should be part of this program.
		5) Many of the costly drugs are for psychiatric problems. A recent FDA advisory suggests that older antipsychotic drugs are safer than some of the new drugs being used. The NMA would assist HHSS in having psychiatrists review these drugs and developing a formulary.
		6) Consider restrictions on other drugs, e.g., antibiotics.
		7) Consider eliminating coverage for over-the-counter medications.
	Prevention/ Education	8) Prevention and education programs to control inpatient hospital utilization.
	Chronic Illness Cost Containment	9) Support of prevention and health education programs will help shift more responsibility to the consumer. Use Community Health Centers and public health agencies to work with clients on prevention and wellness.
		10) Provide follow-up to encourage clients to take medications as prescribed and to make lifestyle changes, which would improve their health.
		11) Encourage more involvement by the public health system to provide follow-up and education to clients.
		12) Develop incentives for clients to keep their appointments and stay on recommended treatment programs. Develop disincentives for those that do not.
	Personal Responsibility	13) For persons with chronic pain/addiction problems, require that they be seen at regular intervals at an approved pain clinic. Retaining Medicaid coverage should be conditioned on the client's follow-through with these treatment programs.

		14) Consumers need to have a financial stake in their insurance plan and health care expenses, but it needs to be at a level which is affordable. 15) Incentives for responsible behaviors, and penalties for destructive behaviors, should be part of the Medicaid program.
	Prenatal Care Improvement	16) Active interventions such as home visits and follow-up by a trained health professional are needed.
	CHCs/Local Health Department's Role	17) Community health clinics and regional/county health departments can reach out and help the uninsured before their problems become severe enough to require Medicaid assistance.
	Inappropriate ED Use	18) Inappropriate use of ED services remains a problem. Tools to decrease this problem have been implemented elsewhere and need to be evaluated for use in Nebraska. Another problem is missed appointments. There needs to be a significant penalty in the system to deal with these problems. Access to an extended hours clinic might be helpful in more urban areas where it is feasible.
	Promotion of Health Insurance	19) Work with the insurance industry to promote affordable health insurance coverage. Need better incentives for employers to offer health insurance to low and middle income employees.
	Under-Utilization of Services	20) Transportation issues need to be addressed. Intervention programs for certain conditions (pregnancy) should be developed.
Nebraska Dental Association	Sustain Provider Base	21) Reduce administrative burdens so that provider enrollment and claims processing mirror commercial dental insurance practice. Consider commercial 3rd party provider to administer claims/program. 22) Prevent erosion of current low reimbursement rates by tying reimbursement rates to a percentage of actual charges submitted. 23) Assure reasonable scope of basic dental care services for all eligible populations, consistent with contemporary dental practice, treatment, and prevention of dental disease.
	Increase Provider Participation to Increase Access to Care	24) Improve current Nebraska Medicaid rates to a market based system. 25) Tie reimbursement rates to a percentage of actual charges submitted, similar to Delaware or a 3rd party provider.
Coalition of: • AARP • ARC of Nebraska • Association of Nebraska Community Action Agencies Center for	Pharmacy	26) Preferred Drug List (open formulary) (Strategy 1) 27) Drug purchasing pools (Strategy 2) 28) Counter detailing or academic detailing (entities other than drug companies, e.g., insurers or purchasers, can provide alternative messages to physicians – Massachusetts targets counter detailing to physicians who prescribe as many as six psychiatric drugs in the same therapeutic class.) The counter detailing could include

People in Need • Children & Family Coalition of Nebraska • March of Dimes-Nebraska Chapter • National Association of Social Workers-NE • Nebraska Advocacy Services, Inc. • Nebraska Appleseed Center for Law in the Public Interest • Nebraska Association of Behavioral Health Organizations • Nebraska Catholic Conference • Nebraska Hospital Association • Nebraska Statewide Indepen-dent Living Council • Visiting Nurse Association of Omaha • Voices for Children in Nebraska		providing physicians with studies showing, for example, that a much-advertised brand-name drug is no more effective than a less expensive, older alternative. (Strategy 3)
	Home and Community Based Services	29) Expand home and community based services (Strategy 4)
	Telemonitoring/ Home Med Units	30) Explore use of a health monitoring system that a patient can use to take his or her own vital signs at home and then transmit the information to a central station for clinical evaluation. Such health monitoring systems may reduce inappropriate hospital/ED admissions. (Strategy 5)
	Smoking Cessation Programs	31) Smoking cessation programs for pregnant women and post-partum mothers (Strategy 6)
	Mental Health	32) Reconsider the requirement that Medicaid recipients receiving outpatient mental health services from a Licensed Mental Health Practitioner, who do not have a major mental illness and are not taking medications for their condition, receive an annual Mental Status Exam. Leave the decision to perform an annual MSE to the LMHP and supervising practitioner. Reconsider the requirement that the annual MSE be performed by the LMHP's supervisory practitioner. Allow for the MSE to be performed by any psychiatrist or psychologist chosen by the client, with the results forwarded to the LMHP. (Strategy 7)
	Home Visitation	33) Consider covering early childhood home visits to improve the health and well-being of pregnant and parenting women with infants and young children. (Strategy 8)
Nebraska Parity Coalition	Mental Health Parity	34) Reconsider mental health parity as a way to reduce the costs of the State's Medicaid program. Current law allows the use of higher deductibles, copayments and coinsurance provisions for the treatment of mental health than for the treatment of physical illnesses. The unequal formula creates clear disincentives for people to seek early mental health treatment, resulting in greater costs down the road.
Area Agencies on Aging	Personal Assistance	35) Reconsider requirement for physician order for personal assistance (PA).
		36) Reconsider the decision to allow HHSS workers outside of Douglas and Sarpy counties to conduct the client self-assessment

		interviews over the phone. 37) Reconsider authorizing hours for laundry, cleaning, etc. for PAs living with the client.
		38) Could the state require PAs to pay for their own background checks?
		39) Look into PAs billing while the client is in the hospital, nursing home, or jail. Look into PAs billing while they are in the hospital or jail. Look into PAs billing but not doing the work.
	Fraud Issues	40) Establish a method for hospital/nursing home admitting clerks to notify HHSS when a person on Medicaid is admitted. This information could be forwarded to the HHSS worker and the person responsible for authorizing the billing sheets.
		41) Establish a mechanism for identifying PAs under investigation or convicted of a crime that would prohibit him or her from being under contract with HHSS.
	Disability Reviews	42) Institute more rigorous annual reviews of disability. Some persons who are no longer disabled are still being considered disabled because of self-reporting which may not be accurate.
	Premium Assistance	43) Consider having Medicaid pay for employer-based health insurance for families when the parents' income is not sufficient to cover the insurance and is within Medicaid income guidelines.
	Cost of In-Home Care Versus Facility Care	44) Examine the cost of in-home care versus the cost of care in a facility.
	Income Guidelines	45) Reexamine income guidelines (1619b).
	Senior Care Options	46) Expand the Senior Care Options program to include a contact by the AAA for everyone seeking nursing facility care.
	Medicaid Waiver	47) Expand the Medicaid Waiver program to encourage home and community-based services as the first option.
	Care Management	48) Expand the Care Management program.
Paula Foster – ENOA Medicaid Case Manager	Medicaid Buy-In	49) Allow working and non-working Medicaid recipients to buy into Medicaid. This would require Medicaid recipients to pay the State of Nebraska Medicaid Program directly, rather than purchasing insurance or having a spend down. Also, persons who are not able to work, but have resources above the FPL, should be able to buy into the Medicaid program.
Steve Hess, Midwest Geriatrics (Florence Home)	Financial Abuse of Older Family Members	50) Make it more difficult for families to financially abuse their older family members.
	Estate Planning to Qualify for Medicaid	51) Place limits on estate planning to qualify for Medicaid.

	Statewide Purchasing Group	52) Consider a statewide purchasing group for products and supplies
Roger Keetle – AARP, MAHSA, MAHCHA, NHCA, and NHA	Long-Term Care	53) Long-Term care savings plan (modeled after the College Savings Plan.
		54) Long-Term Care Insurance Partnership.
	Estate Recovery	55) Medicaid Estate Recoveries.
Mark Intermill - AARP	Long-Term Care	56) New classification of residential long-term care which would provide for some nursing case management, but not on-site 24-hour RN coverage
Nebraska Health Care Association - Pat Snyder	Long-Term Care	57) Long-Term Care Savings Account.
		58) Long-Term Care Partnership Program.
		59) Tax Incentives for purchasing LTC insurance.
		60) Mandatory payroll withholding for long term care.
		61) Support expanded authorized pre-tax contributions to 125 savings accounts for long-term care insurance premiums.
		62) Reduce the frequency which service coordinators visit assisted living facilities.
	Subsidized Premiums	63) State Payment/subsidization of Private Health Insurance Premiums.
	Estate and Asset Policy	64) Estate and Asset Policy Reform.
	Pharmacy	65) Preferred Drug List (for non-psychiatric patients).
	Purchasing Pools – Drugs	66) Purchasing Pools.
	Pay for Quality	67) Pay for Quality/Efficiency.
	Prevention	68) Preventative checkups and testing.
	Cash and Counseling	69) “Money Follows the Person”.
	Case Management	70) Improved Case Management.
	Incentivize NF or ALF to expand services Access	71) Economic Development Incentives.
		72) Improved access to Medicaid Home & Community Based Services.
Mark Intermill, AARP	Prescription Drug Cost Containment	73) Look into Maine Rx Plus and Ohio’s Best Rx drug discount program.

		74) Consider older, less expensive, drugs for the treatment of schizophrenia.
Nebraska's Traumatic Brain Injury Advisory Council	Traumatic Brain Injury	75) Expand the existing TBI waiver to include community-based service options and not be limited to only assisted living. 76) Increase the skills, knowledge and awareness of service providers within existing service delivery systems/training is needed to ensure statewide availability of service providers who are knowledgeable about brain injury. 77) Establish a state-funded Interim Crisis Fund to provide time-limited, flexible assistance in time of need to individuals with disabilities who do not currently qualify for Medicaid or Medicaid waiver services/reduce the number of individuals with disabilities that are forced to go on Medicaid by promoting and funding programs that lead to self-sufficiency through temporary time-limited support.
Vetter Health Services, Inc.	Long-Term Care	78) Where population trends do not indicate an opportunity for future growth, the State of Nebraska would purchase and close small, inefficient long-term care facilities. 79) Create financial incentives for the merger/consolidation of facilities. 80) Allow owners of a facility to transfer their bed license to other locations where population trends dictate a future need so new facilities could be built. 81) Allow the sale of licensed beds to providers who would build new facilities in growth areas, or areas in which population trends would indicate a future need for long-term beds. 82) Work with the Nebraska legislature to pass a law implementing a state tax deduction or credit as an incentive to purchase long-term care insurance.
	Long-Term Care Insurance	83) Provide tax incentives to businesses that offer long-term care insurance as part of their employee benefit package. 84) Customize a preferred drug list for the state's Medicaid program, including drugs that are most useful in patient care, taking into consideration clinical effectiveness and cost.
	Prescription Drug Cost Controls	85) The state should partner with other organizations and states to form purchasing pools to increase purchasing power and reduce costs.
	Estate and Asset Policies	86) Change the asset look-back period from three years to five years. 87) Require individuals who transfer their assets into a trust for estate planning to purchase a long-term care insurance policy to cover their long-term care needs for a minimum of five years. If individuals elect not to purchase a long-term care insurance policy, the trust would be responsible for paying for any long-term care.

		88) Make provision for providers to file liens where they are owed monies to prevent assets from being sold before a lawsuit can be filed and a judgment obtained. 89) Eliminate or reduce the exemption in state law that prevents recovery of the first $5,000 of an estate if children survive the Medicaid beneficiary. 90) Expand the definition of estate to include assets held in joint tenancy with rights of survivorship, life estates, living trusts, etc. 91) Require automatic recoveries of small amounts held by Medicaid recipients in long-term care facilities.
	Elder Financial Abuse	92) Pursue cases of suspected elderly financial abuse by families and responsible parties.
	Long-Term Care Savings Accounts	93) Long-term care savings accounts could be offered as a tax-free savings plan for long-term care, allowing those individuals to deposit a portion of their income each year into their account. Amounts would be withdrawn, tax-free to reimburse long-term care expenses.
	Expanded Pre-Tax Contribution Accounts	94) Allow for long-term care insurance premiums to be deducted pre-tax, and exempt form federal income and Social Security taxes as allowed under the Internal Revenue Code – Section 125.
	Eliminate Work Disincentives	95) Eliminate the disincentive for Medicaid beneficiaries to work full-time or additional hours, making them exceed the income eligibility levels and losing health insurance coverage.
	Payments for Services Provided in an Alternative Setting	96) Payments made by the State for services provided to an individual residing outside of a long-term care facility should not exceed the average payment that the State would have paid if the individual resided in a long-term care facility.
	Work Comp Laws	97) Pass work comp laws that would penalize a person and/or doctor for falsifying an injury for the purpose of extending benefits.
	Tort Reform	98) Pass stricter tort reform laws to prevent excessive settlements that, in turn, would reduce liability insurance premiums.
	Create Incentives for People to Enter the Health Care Profession	99) The State of Nebraska and providers should work together to create incentives and scholarships for students attending LPN and RN programs. 100) Provide grants for students who wish to become CNAs and CMAs. 101) To control agency labor usage, there needs to be more professionals in the health care field.
Nebraska Foundation for Medical Care (NFMC)	Review of Eligibility	102) Unless there is an internal department review, no one does a review of eligibility in the payment process for accuracy. When NFMC did a Payment Accuracy Methodology (PAM) review, we found a significant number of errors regarding payment issues, including:

Out-of-state payments – we have seen several patient with out-of-state addresses who receive benefits from Nebraska Medicaid. We are unsure if they are ever corrected by Nebraska Medicaid.

Worker's Compensation – Medicaid has been billed for services provided which were direct results of a work-related injury. This could be screened more effectively if patient records associated with trauma or injury were screened from time to time.

Care Management

103) Persons with high Medicaid expenditures need someone to coordinate their care. We have reviewed charts where the care is being provided in a fragmented fashion which puts the patient at risk of needing further very expensive care. The Department needs to hire and train a small group of case managers for these patients (and not add them into an already busy caseworkers' caseload).

One Day Stays

104) The current language in the Regulations regarding inpatient care, outpatient care, and the "24 hour rule" is outdated and causes problems including payment issues because of the rigidity of the rules. A change would allow more consistency and probably save money.

Pre-Authorizations

105) The Rules and Regulations pertaining to coverage of certain high-cost procedures are somewhat vague and no follow up is done to determine if the procedure performed actually improved the patient's condition.

Multiple vs. Repetitive Single Procedures

106) There is no consistent review of procedures where multiple procedures are being performed which could have been done at the same time but which are being done separately. The Coding System allows billing for separate procedures done at separate times, when if performed at the same session they would be billed as the initial procedure and multiple subsequent procedures (billed at 50% or less of the initial procedure). This adds to HHSS expense.

Newborn Care

107) The Diagnosis Related Groups (DRG) system was originally developed for Medicare and subsequently expanded to include other conditions. Newborn Care is an area, which creates significant problems. Anything about a child that is even mildly abnormal can change the DRG, resulting in a dramatic shift in reimbursement. We encourage HHSS to consider requesting a re-evaluation of these DRGs, or the addition of a DRG to more accurately reflect children who may have a minor congenital condition, without jumping to a much higher paying DRG. If unable to change this, HHSS may wish to consider changing it's Rules and Regulations to control billing in this area.

Rehab Transfers

108) Since hospitals are reimbursed on a DRG basis for inpatient care, it is to their advantage to move a patient as soon as stabilized to a Rehab situation. This becomes more problematic if there is also a rehab unit as a part of the hospital. NFMC has seen cases where a patient was transferred to a rehab unit (generally it is expected that the rehab stay would be several weeks in duration) only to be discharges within a few days. NFMC is concerned that had the patient stayed in the acute care setting a day or two more, the rehab stay would not have been necessary. Since NFMC does pre-authorizations for rehab stays, this can sometimes be caught before

		the patient goes to the rehab unit. However, with retrospective reviews, where the patient becomes eligible retrospectively, NFMC has no way to control this and are frequently asked to reconsider these areas.
Nebraska Pharmacists Association	Expand Prior Authorizations	109) Consider putting all new drugs on prior authorization until the Drug Use Review (DUR) Board can review them.
	Appropriate Prescribing/Use	110) Establish prescriber education program for proper prescribing, therapy and utilization of atypical antipsychotics (mental health medications) and for anti-infectives.
	Pharmacist-Based Medication Therapy Management	111) Implement pharmacist-based medication therapy management services.
	Protect Access to Pharmacists in Rural Areas	112) Protect access to pharmacists in rural areas. Consider providing incentives to pharmacists to provide medication therapy management services, dispense generics, and continued drug utilization reviews.
	Co-Payments and Eligibility Determination	113) Review the residency requirements for Nebraska Medicaid eligibility. Individuals should be residents of NE for a set amount of time (at least 6 months) before becoming eligible for Medicaid.
		114) Co-payments for prescription drugs should be mandated to curb abuse of the Medicaid system.
	Medicare Modernization Act (MMA)	115) Insist that CMS provide oversight and management of the Medicare/Medicaid eligible (dual-eligible) population to ensure proper therapies and utilization, as well as patient adherence, to control costs.
	Provider Services	116) Improve provider services by creating a more efficient system of submitting claims for durable medical equipment, supplies, and nutritional supplements.
Planned Parenthood of Nebraska & Council Bluffs	Family Planning Waivers	117) Investigate Medical family planning eligibility expansions (i.e., family planning waivers). (Twenty-two states currently have obtained family planning waivers.)

Attachment 3
Medicaid Reform Meetings/Presentations
2005

February
Health and Human Services Committee, Nebraska Legislature

March
Children and Family Coalition of Nebraska

April
Nebraska Association of Private Residential Resources
Nebraska Hospital Association
Nebraska Association of Homes and Services for the Aging
Nebraska Health Care Association

May
Nebraska Consortium of Citizens with Disabilities
Nebraska Medical Association
Heartland Health Alliance

June
Health and Human Services staff
ARC of Nebraska

July
Nebraska Pharmacists Association
AARP Nebraska

August
Nebraska Area Agencies on Aging

September
Nebraska Medical Association
Rural Health Advisory Commission
Nebraska Dental Association
Catholic Charities of Nebraska
Multi-Agency Medicaid coalition[13]
Children and Families Coalition of Nebraska
Traumatic Brain Injury Advisory Council

[13] Including representatives from AARP Nebraska, ARC of Nebraska, Association of Nebraska Community Action Agencies, Center for People in Need, Children and Families Coalition of Nebraska, March of Dimes - Nebraska Chapter, National Association of Social Workers - Nebraska Chapter, Nebraska Advocacy Services, Nebraska Appleseed Center for Law in the Public Interest, Nebraska Association of Behavioral Health Organizations, Nebraska Catholic Conference, Nebraska Hospital Association, Nebraska Psychological Association, Nebraska Statewide Independent Living Council, Visiting Nurses Association of Omaha, and Voices for Children of Nebraska.

Nebraska Consortium for Citizens with Disabilities
Mental Health Association of Nebraska Consumer Work Group

October
Nebraska Nurses Association
Rural Health Stakeholders Legislative Coalition
Mental Retardation Association of Nebraska
Nebraska Minority Health Association

Attachment 4
HHSS Medicaid Reform Work Group Recommendations

Medicaid Alternatives

1. Create a Safety Net Commission to develop a plan for expanding and supporting the number of community health centers, satellites of existing centers, and look-alikes.
2. Expand the use of drug discount programs (e.g., the federal 340B Program) so that all eligible organizations can purchase prescription drugs at lower costs.
3. Create public-private partnerships between small employers and Medicaid through Premium Assistance Programs
4. Conduct a study to determine the feasibility of implementing a publicly-financed reinsurance program
5. Use tax subsidies to encourage the purchase of health insurance
6. Encourage more employers to offer and employees to purchase Health Savings Accounts
7. Explore the development of a large purchasing pool for health insurance

Children with Disabilities

1. Require parents to pay a premium for the medical care of minor children living in the home covered by a Home and Community Based waiver (Section 1915(c) or a Katie Beckett waiver (Section 1902(e)(3))
2. Implement a Developmental Disabilities (DD) quality management system
3. Combine existing waivers into a Medically Fragile Children's Waiver
4. Public information campaign to encourage parents to insure their children

Adults

1. Find solutions for the uninsured
2. Wellness/prevention initiatives/individual responsibility
3. Address large-scale cost of health care issues
4. Disease Management
5. Assess feasibility of enrolling pregnant women instead of unborn children
6. Administrative cost containment initiatives

Adults with Disabilities

1. Disease Management and health maintenance
2. Implement mandatory screening for nursing facility and ICF-MR admissions
3. Eliminate the institutional bias in funding and social policy decisions
4. Maximize federal Medicaid funding for community services with HCBS waivers while reducing the number of Nebraskans receiving institutional care
5. Remove exemptions of trusts for determining Medicaid eligibility
6. Eliminate Public Service Commission control over HHSS transportation options and expenditures
7. Implement HHSS staff as specialized case managers for high cost populations
8. Reduce durable medical equipment costs by use of the Assistive Technology Partnership

9. Reduce Medicaid costs resulting from motor vehicle injury
10. Provide vouchers to clients to purchase services directly (Cash and Counseling)
11. Support federal policy changes which would eliminate the two year wait for Medicare upon determination of disability

Aged

1. Encourage individuals to take responsibility for their own long-term care planning
2. Reverse Mortgages
3. Facilitate/foster personal responsibility for long-term care needs through promotion of, and education about, the benefits of advance planning and through positive incentives
4. Promote preventative health and education
5. Support the legislative initiative of NGA and the Medicaid Commission to close loopholes in asset transfers (Medicaid Estate Planning)
6. Mandate expansion of screening process used for Medicaid recipients to all newly admitted nursing facility residents
7. Vouchers or cash allowances/consumer-directed services
8. Educate hospital discharge planners about HCBS options
9. Require nursing facilities to disseminate Home and Community Based service information and use community based organizations to conduct information sessions at such facilities
10. Establish local long-term care coalitions
11. Reduce barriers to aging in place
12. Petition federal government to have Medicare assume full responsibility for the health care needs of their beneficiaries
13. Encourage the development, training and retention of a qualified long-term care work force in Nebraska
14. Expand waiver slots/services to accommodate population growth
15. Establish an additional level of assisted living care to recognize differences in resident care needs
16. Explore possibility of implementing a Medicaid waiver program for persons with mental illness who meet nursing home level of care criteria but whose needs could be safely met in an assisted living facility or at home
17. Encourage CMS to require that the new Medicare Drug Plan providers share information on Medicaid consumers' drug utilization with state Medicaid agencies
18. Develop a process that would provide for professional review of the prescribing of psychotropic medications
19. Move Medicaid nursing facility payments away from cost-based reimbursement to incentivize higher occupancy and greater efficiency
20. Remove the $5,000 exempt property deduction for adult children in estate recovery collection process, and expand estate recovery efforts
21. Evaluate the feasibility of Medicaid coverage of emerging alternatives to traditional nursing facility care, such as the Green House Project
22. Convert from full-month to partial-month coverage at the beginning and end of a person's Medicaid eligibility

23. Allow individuals who are paying insurance premiums for the purpose of becoming eligible to pay the State Medicaid program directly
24. Explore possibility of sending Explanation of Benefits (EOBs) to Medicaid consumers each month.
25. Use Adult Day Care services as a possibly cheaper way to help people recover from health problems or surgery outside of the hospital

Healthy Children and Pregnant Women

1. Make the pregnant woman the covered person for Medicaid rather than the unborn child
2. Improve access to and utilization of quality preventive health through EPSDT, including dental services and prenatal care
3. Develop best practice guidelines for prescribing psychotropic drugs to children
4. Enroll only fully licensed MH/SA providers
5. Cost containment through program management
6. Require that State Wards with private insurance utilize services in the network
7. Collect a case management fee or premium for MH/SA services for State Wards
8. Review and management of services to State Wards
9. Implement a separate SCHIP program
10. Require parents of State Wards to assign medical benefits to the state

Appendix 5
Medicaid-Related Statutes
Neb. Rev. Stat. §68-1001 to §68-1086
(in statutory numerical order)

Subject	Statutes	Bill
1. Assistance to the Aged, Blind, or Disabled (AABD)	68-1001 to 68-1008	c. 395 (1965)
2. Assistance generally (AABD, ADC, MA, Food Stamps); Appeal of Denial; Violations; Ineligibility	68-1013 to 68-1017.02	c. 394 (1965)
3. Medical Assistance (Medicaid)	68-1018 to 68-1025	c. 397 (1965)
4. Public awareness re: Medicaid children's health services	68-1025.01	LB 1063 (1998)
5. Assignment of rights	68-1026 to 68-1028	LB 723 (1984)
6. Contracts to promote the goal of medical cost containment	68-1029 to 68-1036	LB 904 (1984)
7. Medicaid estate recovery and garnishment	68-1036.02 to 68-1036.03	LB 1224 (1994)
8. Legislative findings re: prenatal care to pregnant women and care to infants under Medicaid and Title XXI	68-1037	LB 455 (1995)
9. Spousal impoverishment	68-1038 to 68-1043	LB 419 (1988)
10. Managed Care Plan Act	68-1048 to 68-1063	LB 816 (1993)
11. Additional Medicaid managed care provisions	68-1067 to 68-1069	LB 258 (1997)
12. Eligibility for non-U.S. citizens	68-1070	LB 864 (1997)
13. Medicaid administrative activities by public schools and ESUs	68-1071 to 68-1072	LB 548 (1999)
14. False Medicaid Claims Act	68-1073 to 68-1086	LB 1084 (2004)